

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 06/10/01 through 07/09/01 (1-month rental)?
b. The request was received on 02/25/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC-60 undated position statement
 - b. HCFAs
 - c. EOBs
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and Response to a Request for Dispute Resolution dated 03/19/02
 - b. Audit summaries/EOB
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 05/01/02. Per Rule 133.307 (g)(4), the carrier received its copy on 05/06/02. The only response from the insurance carrier was received in the Division on 03/21/02. The findings and decision will be based on all documentation submitted by both parties.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: per undated position statement
"Payment has been made based on old fee guidelines for E0745, which had a D code in the pre 1996 fee schedule...The commission has not established a maximum allowable for the RS4I Sequential Stimulator...There are no fee guidelines for devices billed under E1399. Fee guidelines call for reimbursement at fair and reasonable rates...We are also including copies of EOBs from carriers who are paying at our list price."

2. Respondent: letter dated 03/19/02
 “The provider is seeking additional reimbursement for rental of RS4I...(Carrier) reimburses stimulator rental at a fair and reasonable rate of \$150.00 per month...Enclosed please find copies of EOB’S...showing payments made for rental of a RS4I...which was accepted by this provider.”

IV. FINDINGS

- Based on Commission Rule 133.307(d)(1&2), the only dates of service eligible for review are 06/10/01 through 07/09/01 (1-month rental).
- The carrier’s EOB has the denial “F – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUES AS ESTABLISHED BY INGENIX.”
- The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MARS	REFERENCE	RATIONALE:
06/10/01-07/09/01 (1 month rental)	E1399	\$250.00	\$150.00	F	DOP	Texas Workers’ Compensation Act & Rules, Sec. 413.011 (d), Rule 133.304 (i); MFG, GI (III)	Due to the fact there is no current fee guideline for the DME provided, the Medical Review Division has to determine based on the parties’ submission of information, what represents fair and reasonable reimbursement. The MFG, GI (III) states, “(DOP) in the ...(MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill.” This places the burden on the provider to show what is fair and reasonable reimbursement. Both the carrier and the provider have submitted EOBs in support of their positions. The provider’s EOBs show a higher rate of reimbursement, the carrier’s EOBs show what has been accept as “fair and reasonable” reimbursement. However, an analysis of recent State Office of Administrative Hearings decisions show minimal weight is given to EOBs when used to document “fair and reasonable” reimbursement. The fact a carrier routinely reimburses a certain amount does not necessarily document that amount is fair and reasonable. The willingness of some carrier’s to reimburse at or near the billed amount does not necessary document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011 (d). Based on the documentation available for review, the provider has failed to meet its burden of proof and no additional reimbursement is recommended.
Totals		\$250.00	\$150.00				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 1st day of July, 2002.

Larry Beckham
 Medical Dispute Resolution Officer
 Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers’ Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.